Global Mental Health: A Critical Introduction

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The Division of Social and Transcultural Psychiatry is a network of scholars and clinicians within the Department of Psychiatry, Faculty of Medicine, McGill University, devoted to promoting research, training and consultation in social and cultural psychiatry.

The broad themes of research and training conducted by members of the Division include:

**Social Psychiatry**
- psychiatric epidemiology
- social causes and consequences of psychiatric disorders
- psychiatry in primary care
- social treatments, rehabilitation and prevention strategies
- evaluation of services

**Cultural Psychiatry**
- mental health of indigenous peoples, ethnocultural minorities, immigrants and refugees
- international community mental health
- indigenous healing practices, ethnopsychology and ethno psychiatry
- cultural critique of Western psychiatric theory and practice
Mission Statement

The McGill Global Mental Health Program (GMHP) is a multidisciplinary research and training hub based at the Department of Psychiatry in the Division of Social and Transcultural Psychiatry. The program is dedicated to the advancement of knowledge and action research on mental health disparities around the world, especially in low- and middle income countries (LMIC).

GMHP promotes a multi-disciplinary research agenda with a particular focus on bringing the social science’s perspectives to bear on the understanding and response to mental health problems internationally. Building on McGill’s longstanding tradition in cultural psychiatry and the university’s excellent mental health research community, the Global Mental Health Program creates a collaborative space and training environment through

- Multi-disciplinary action research
- Platforms for dialogue and networking (GMH seminar series & film series)
- Training opportunities for students (e.g. annual summer school)
- Capacity building (across Canada & in LMICs)
- Knowledge exchange and translation

CONGRATULATIONS to the 2017 Duncan Pederson Graduate Award winner, Helen Martin.

www.mcgill.ca/gmh
Global Mental Health Program

Programme mondial pour la santé mentale

McGill Global Health Programs

PROGRAMMES DE SANTÉ MONDIALE
Outline

• global mental health and the Movement for Global Mental Health

• the logic of GMH: psychiatric epidemiology, DALYs and disparities

• the practice of GMH: mhGAP and task shifting

• Grand Challenges for GMH

• critique of GMH

• culture and context pluralism and forms of knowledge

• example of mental health promotion with Indigenous communities in Canada

• implications for research, training and practice
No health without mental health

Martin Prince, Vikram Patel, Shekhar Saxena, Mario Maj, Joanna Maselko, Michael R Phillips, Atif Rahman

About 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders, and psychoses. Such estimates have drawn attention to the importance of mental disorders for public health. However, because they stress the separate contributions of mental and physical disorders to disability and mortality, they might have entrenched the alienation of mental health from mainstream efforts to improve health and reduce poverty. The burden of mental disorders is likely to have been underestimated because of inadequate appreciation of the connectedness between mental illness and other health conditions. Because these interactions are protean, there can be no health without mental health. Mental disorders increase risk for communicable and non-communicable diseases, and contribute to unintentional and intentional injury. Conversely, many health conditions increase the risk for mental disorder, and comorbidity complicates help-seeking, diagnosis, and treatment, and influences prognosis. Health services are not provided equitably to people with mental disorders, and the quality of care for both mental and physical health conditions for these people could be improved. We need to develop and evaluate psychosocial interventions that can be integrated into management of communicable and non-communicable diseases. Health-care systems should be strengthened to improve delivery of mental health care, by focusing on existing programmes and activities, such as those which address the prevention and treatment of HIV, tuberculosis, and malaria; gender-based violence; antenatal care; integrated management of childhood illnesses and child nutrition; and innovative management of chronic disease. An explicit mental health budget might need to be allocated for such activities. Mental health affects progress towards the achievement of several Millennium Development Goals, such as promotion of gender equality and empowerment of women, reduction of child mortality, improvement of maternal health, and reversal of the spread of HIV/AIDS. Mental health awareness needs to be integrated into all aspects of health and social policy, health-system planning, and delivery of primary and secondary general health care.

Introduction

The WHO proposition that there can be “no health without mental health” has also been endorsed by the Pan American Health Organisation, the EU Council of Ministers, the World Federation of Mental Health, and the UK Royal College of Psychiatrists. What is the substance of this slogan?

Mental disorders make a substantial independent contribution to the burden of disease worldwide (panel 1).1 WHO’s 2005 estimates of the global burden of disease provide evidence on the relative effect of health problems worldwide.14 Non-communicable diseases are rapidly becoming the dominant causes of ill health in all developing regions except sub-Saharan Africa (table 1).1 The Global Burden of Disease report has revealed the scale of the contribution of mental disorders, by use of an integrated measure of disease burden—the disability-adjusted life-year, which is the sum of years lived with disability and years of life lost.1 The report showed that neuropsychiatric conditions account for up to a quarter of all disability-adjusted life-years, and up to a third of those attributed to non-communicable diseases, although the size of this contribution varies between countries according to income level (table 1).1 The neuropsychiatric conditions that contribute the most disability-adjusted life-years are mental disorders, especially unipolar and bipolar affective disorders, substance-use and alcohol-use disorders, schizophrenia, and dementia. Neurological disorders (such as migraine, epilepsy, Parkinson’s disease, and multiple sclerosis) make a smaller but still significant contribution. Of the non-communicable diseases, neuropsychiatric conditions contribute the most to overall burden (figure 1 and table 1),4 more than either cardiovascular disease or cancer.

Search strategy

We searched relevant databases (Medline, PubMed, Embase, and the Cochrane Library of systematic reviews and clinical trials) with the following Mesh terms: “mental disorders”, “substance-related disorders”, “cardiovascular diseases”, “cerebrovascular disorders”, “diabetes mellitus”, “diabetes complications”, “HIV infections”, “malaria”, “tuberculosis”, “genital diseases”, “female”, “infant nutrition disorders”, “and accidents”, together with the PubMed clinical queries algorithms for aetiology, prognosis, treatment, and systematic reviews. For non-communicable disorders (coronary heart disease, stroke, and diabetes), and communicable disorders (HIV/AIDS, tuberculosis, and malaria) we focused on index conditions that are especially salient to public health. We concentrated on papers published since 2000, and have prioritised evidence from low-income and middle-income countries and from systematic reviews and meta-analyses. We have cited subsequent publications if they provided new information.
About the movement

The Movement for Global Mental Health is a network of individuals and organisations that aim to improve services for people living with mental health problems and psychosocial disabilities worldwide, especially in low- and middle-income countries where effective services are often scarce. Two principles are fundamental to the Movement: scientific evidence and human rights.

The history of the Movement began in 2007 with a Call for Action published in the first Lancet series on global mental health. Through volunteering and commitment, the Movement has continued to evolve.

Media

5 OCTOBER 2014
The ‘cette’ prognosis hypothesis for schizophrenia in poor countries. Is it the medication?

10 SEPTEMBER 2014
INTERNATIONAL LEADERS UNITE UNIFOR ‘FUNDAMENTAL SUC’
CREATE GLOBAL MOVEMENT IN INCLUSION OF MENTAL HEALTH IN THE UNITED NATIONS’ 2015 POST-2015 DEVELOPMENT AGENDA

23 AUGUST 2014
Mental health is a world-wide goal

11 AUGUST 2014
Broken Light: A Photogrpahy Collective Embracing The Depression in Our Lives

Latest activity

28 OCTOBER 2014
Global Mental Health—new journal added to Resources.

22 AUGUST 2014
Including mental health among the new sustainable development goals added to Resources.

22 AUGUST 2014
A position statement on mental health in the post-2015 development agenda added to Resources.

3 JULY 2014
Global Mental Health Trials added to Resources.
Cross-Cutting Themes & Issues

• Global mental health exists against the historical background and ongoing reconfigurations of colonialism, postcolonialism, neocolonialism, and the contexts of globalization

• psychiatrization and psychologization play an important role in emerging forms of personhood in modernity

• psychiatric institutions contribute to social control, regulation, and legitimation not only through carceral functions but increasingly through epistemic regimes of evidence and authority

• the process of making global mental health a movement aims to mobilize resources but raises a set of new political, organizational and conceptual questions
Logic of the GMH Movement

The GMH movement makes four key moves:

1. documenting the enormous disparities in mental health in low and middle income countries

2. arguing these should be a higher priority in development (not secondary to other public health measures in infectious and communicable diseases)

3. framing the disparity in terms of a treatment gap

4. aiming to identify, test, and scale-up evidence-based interventions to meet the treatment gap.
The **disability-adjusted life year (DALY)** is a measure of overall disease burden. Originally developed by the [World Health Organization](https://www.who.int). Traditionally, health liabilities were expressed using one measure: (expected or average number of) **Years of Life Lost (YLL)**. This measure does not take the impact of disability into account, which can be expressed by: **Years Lived with Disability (YLD)**.

DALYs are calculated by taking the sum of these two components. In a formula: \[DALY = YLL + YLD.\]
The prevention, identification, and psychological autopsy studies in India and China were important elements of suicide prevention. It is crucial to manage mental health problems appropriately, as mental disorders are independently associated with a substantial excess in all-cause mortality risk. Most studies have focused on associations with depression, linking diagnosis with subsequent all-cause mortality. A meta-analysis of 15 population-based studies reported that depression diagnosis was linked with subsequent all-cause mortality, and yielded a pooled odds ratio (OR) of 1.22-2.23. Findings from this analysis are consistent with the evidence showing a major role of mental health problems in contributing to total DALYs. The attributable fraction of 47–74% indicates the substantial contribution of mental disorders to the global burden of disease. Focusing on disordered eating, a study found that 13–34% of people with eating disorders had died by age 24, with higher death rates for women compared to men. Table 1 breaks down the DALYs contributed by different non-communicable diseases, showing a substantial contribution from neuropsychiatric conditions. Figure 1 illustrates the contribution by different non-communicable diseases to disability-adjusted life-years worldwide in 2005, indicating the importance of mental health conditions in global burden of disease. Data adapted from WHO, with permission.
40. Median number of psychiatric beds per 10 000 population

<table>
<thead>
<tr>
<th>WHO Regions</th>
<th>Median per 10 000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>0.34</td>
</tr>
<tr>
<td>Americas</td>
<td>2.60</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>1.07</td>
</tr>
<tr>
<td>Europe</td>
<td>8.00</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>0.33</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>1.06</td>
</tr>
<tr>
<td>World</td>
<td>1.69</td>
</tr>
</tbody>
</table>

N = 185

47. Median number of psychiatrists per 100 000 population

<table>
<thead>
<tr>
<th>WHO Regions</th>
<th>Median per 100 000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>0.04</td>
</tr>
<tr>
<td>Americas</td>
<td>2.00</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>0.95</td>
</tr>
<tr>
<td>Europe</td>
<td>9.80</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>0.20</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>0.32</td>
</tr>
<tr>
<td>World</td>
<td>1.20</td>
</tr>
</tbody>
</table>

N = 187
However, the resources provided to tackle the huge burden of MNS disorders have remained insufficient. Almost a third of countries still do not have a specific budget for mental health. Of the countries that have a designated mental health budget, 21% spend less than 1% of their total health budgets on mental health. Figure 1 compares the burden of mental disorders with the budget assigned to mental health; it shows that countries allocate disproportionately small percentages of their budgets to mental health compared with their burdens.

The scarcity of resources is further compounded by inequity in their distribution. Data from WHO’s Atlas Project illustrate the scarcity of resources for mental health care in countries with low and middle incomes. Although most countries assign a low proportion of their health budgets to mental health, for countries with low gross domestic product (GDP), this proportion is even smaller (figure 2).

The scarcity of resources is even greater for human resources; figure 3 presents the distribution of human resources for mental health across different income categories.

There is also inefficiency in the use of scarce and inequitably distributed resources. For example, many middle-income countries that have made substantial investments in large mental hospitals are reluctant to replace them with community-based and inpatient facilities in general hospitals, despite evidence that mental hospitals provide inadequate care and that community-based services are more effective.

Figure 1: Burden of mental disorders and budget for mental health

- **Red**: Proportion of disability-adjusted life years (DALYs) attributable to mental disorders
- **Blue**: Median proportion of total health budget allocated to mental health
  (Source: Mental Health Atlas, WHO, 2005)
Scaling up care for mental, neurological, and substance use disorders thus needs to be accelerated; and allocation of more resources to these areas will be critical to this process. WHO has received an increasing number of requests from countries for assistance and country-specific action. The need for – and relevance of – an economic perspective in planning, provision, and assessment of services, and for scaling up care for MNS disorders is another reason to revise the focus of the mental health strategy. Moreover, a comprehensive programme for action can inspire stakeholders and accelerate progress by bringing together partners with a common purpose. Another stimulus for revision of the mental health strategy has been the recent publication of a Lancet series on global mental health, which addressed mental health issues in countries with low and middle incomes. The series culminated in a call for action to the global health community for scaling up services for mental health care in these countries. The series concluded that the evidence and solutions for dealing with the global burden of mental health are at hand. What is needed is political will, concerted action by a range of global health stakeholders, and the resources to implement them. The situation is similar for neurological and substance use disorders.

**Figure 3: Human resources for mental health care in each income group of countries, per 100,000 population**

(Source: Mental Health Atlas, WHO 2005)
mhGAP Intervention Guide
for mental, neurological and substance use disorders
in non-specialized health settings

World Health Organization
mental health Gap Action Programme
mhGAP-IG Master Chart: Which priority condition(s) should be assessed?

1. These common presentations indicate the need for assessment.
2. If people present with features from more than one condition, then all relevant conditions need to be assessed.
3. All conditions apply to all ages, unless otherwise specified.

<table>
<thead>
<tr>
<th>COMMON PRESENTATION</th>
<th>CONDITION TO BE ASSESSED</th>
<th>GO TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Low energy, fatigue; sleep or appetite problems</td>
<td>Depression **</td>
<td>DEP</td>
</tr>
<tr>
<td>• Persistent sad or anxious mood; irritability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Low interest or pleasure in activities that used to be interesting or enjoyable</td>
<td></td>
<td></td>
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<tr>
<td>• Multiple symptoms with no clear physical cause (e.g. aches and pains, palpitations, numbness)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Difficulties in carrying out usual work, school, domestic or social activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Abnormal or disorganized behaviour (e.g. incoherent or irrelevant speech, unusual appearance, self-neglect, unkempt appearance)</td>
<td>Psychosis *</td>
<td>PSY</td>
</tr>
<tr>
<td>• Delusions (a false firmly held belief or suspicion)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hallucinations (hearing voices or seeing things that are not there)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Neglecting usual responsibilities related to work, school, domestic or social activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Manic symptoms (several days of being abnormally happy, too energetic, too talkative, very irritable, not sleeping, reckless behaviour)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Convulsive movement or fits/seizures</td>
<td>Epilepsy / Seizures</td>
<td>EPI</td>
</tr>
<tr>
<td>• During the convulsion:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Loss of consciousness or impaired consciousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Stiffness, rigidity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Tongue bite, injury, incontinence of urine or faeces</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• After the convulsion: fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache, muscle aches, or weakness on one side of the body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Delayed development: much slower learning than other children of same age in activities such as smiling, sitting, standing, walking, talking/communicating and other areas of development, such as reading and writing</td>
<td>Developmental Disorders</td>
<td>DEV</td>
</tr>
<tr>
<td>• Abnormalities in communication, restricted, repetitive behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Difficulties in carrying out everyday activities normal for that age</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Children and adolescents
Excessive inattention and absent-mindedness, repeatedly stopping tasks before completion and switching to other activities
Excessive over-activity: excessive running around, extreme difficulties remaining seated, excessive talking or fidgeting
Excessive impulsivity: frequently doing things without forethought
Repeated and continued behaviour that disturbs others (e.g. unusually frequent and severe temper tantrums, cruel behaviour, persistent and severe disobedience, stealing)
Sudden changes in behaviour or peer relations, including withdrawal and anger

Decline or problems with memory (severe forgetfulness) and orientation (awareness of time, place and person)
Mood or behavioural problems such as apathy (appearing uninterested) or irritability
Loss of emotional control – easily upset, irritable or tearful
Difficulties in carrying out usual work, domestic or social activities

Appearing to be under the influence of alcohol (e.g. smell of alcohol, looks intoxicated, hangover)
Presenting with an injury
Somatic symptoms associated with alcohol use (e.g. insomnia, fatigue, anorexia, nausea, vomiting, indigestion, diarrhoea, headaches)
Difficulties in carrying out usual work, school, domestic or social activities

Appearing drug-affected (e.g. low energy, agitated, fidgeting, slurred speech)
Signs of drug use (injection marks, skin infection, unkempt appearance)
Requesting prescriptions for sedative medication (sleeping tablets, opioids)
Financial difficulties or crime-related legal problems
Difficulties in carrying out usual work, domestic or social activities

Current thoughts, plan or act of self-harm or suicide
History of thoughts, plan or act of self-harm or suicide

* The Bipolar Disorder (BPD) module is accessed through either the Psychosis module or the Depression module.
* The Other Significant Emotional or Medically Unexplained Complaints (OTH) module is accessed through the Depression module.
Psychosis is characterized by distortions of thinking and perception, as well as inappropriate or narrowed range of emotions. Incoherent or irrelevant speech may be present. Hallucinations (hearing voices or seeing things that are not there), delusions (fixed, false idiosyncratic beliefs) or excessive and unwarranted suspicions may also occur. Severe abnormalities of behaviour, such as disorganized behaviour, agitation, excitement and inactivity or overactivity, may be seen. Disturbance of emotions, such as marked apathy or disconnect between reported emotion and observed affect (such as facial expressions and body language), may also be detected. People with psychosis are at high risk of exposure to human rights violations.
Psychosis

Assessment and Management Guide

1. Does the person have acute psychosis?
   - Incoherent or irrelevant speech
   - Delusions
   - Hallucinations
   - Withdrawal, agitation, disorganized behaviour
   - Beliefs that thoughts are being inserted or broadcast from one’s mind
   - Social withdrawal and neglect of usual responsibilities related to work, school, domestic or social activities

   If multiple symptoms are present, psychosis is likely.

   If this episode is:
   - the first episode OR
   - a relapse OR
   - worsening of psychotic symptoms
   it is an acute psychotic episode

   Rule out psychotic symptoms due to:
   - Alcohol or drug intoxication or withdrawal (Refer to Alcohol use disorder/Drug use disorder module » ALC and » DRU)
   - Delirium due to acute medical conditions such as cerebral malaria, systemic infections/sepsis, head injury

   Yes

   Provide education to the person and carers about psychosis and its treatment. » PSY 2.1
   Begin antipsychotic medication. » PSY 2.1
   If available, provide psychological and social interventions, such as family therapy or social skills therapy. » INT
   Facilitate rehabilitation. » PSY 2.2
   Provide regular follow-up. » PSY 2.3
   Maintain realistic hope and optimism.

   Note: DO NOT prescribe anticholinergic medication routinely to prevent antipsychotic side-effects.

   Yes

2. Does the person have chronic psychosis?
   - When this episode began
   - Whether any prior episodes occurred
   - Details of any previous or current treatment

   If symptoms persist for more than 3 months
   chronic psychosis is likely

   IF THE PERSON IS NOT ON ANY TREATMENT, START TREATMENT AS FOR ACUTE PSYCHOTIC EPISODE.

   Review and ensure treatment adherence.
   If the person is not responding adequately, consider increasing current medication or changing it. » PSY 3.1 and 3.2
   If available, provide psychological and social interventions such as family therapy or social skills therapy. Consider adding a psychosocial intervention not offered earlier, e.g. cognitive behavioural therapy if available. » INT
   Provide regular follow-up. » PSY 2.3
   Maintain realistic hope and optimism.
   Facilitate rehabilitation. » PSY 2.2
Psychosis

Assessment and Management Guide

3. Is the person having an acute manic episode?

**Look for:**
- Several days of:
  - Markedly elevated or irritable mood
  - Excessive energy and activity
  - Excessive talking
  - Recklessness
- Past history of:
  - Depressed mood
  - Decreased energy and activity
  (see Depression Module for details).

**NOTE:**
- People who suffer only manic episodes (without depression) are also classified as having bipolar disorder.
- Complete recovery between episodes is common in bipolar disorder.

**YES**

If yes, this could be bipolar disorder

- Exit this module and go to Bipolar Disorder Module. »BPD

4. Look for concurrent conditions

- Alcohol use or drug use disorders
- Suicide/self-harm
- Dementia
- Concurrent medical illness: Consider especially signs/symptoms suggesting stroke, diabetes, hypertension, HIV/AIDS, cerebral malaria or medications (e.g. steroids)

**Woman of child-bearing age?**

**YES**

If yes, then

- Manage both the psychosis and the concurrent condition.

**NOTE:**
- In the case of a pregnant woman, liaise with the maternal health specialist, if available, to organize care.
- Explain the risk of adverse consequences for the mother and her baby, including the risk of obstetric complications and psychotic relapse (particularly if medication is changed or stopped).
- Women with psychosis who are planning a pregnancy, pregnant, or breastfeeding should be treated with low-dose oral haloperidol or chlorpromazine.
- Avoid routine use of depot antipsychotics.
Psychosis

Intervention Details

Psychosocial Interventions

2.1 Psychoeducation

» Messages to the person with psychosis
  – the person’s ability to recover;
  – the importance of continuing regular social, educational and occupational activities, as far as possible;
  – the suffering and problems can be reduced with treatment;
  – the importance of taking medication regularly;
  – the right of the person to be involved in every decision that concerns his or her treatment;
  – the importance of staying healthy (e.g. healthy diet, staying physically active, maintaining personal hygiene).

» Additional messages to family members of people with psychosis
  – The person with psychosis may hear voices or may firmly believe things that are untrue.
  – The person with psychosis often does not agree that he or she is ill and may sometimes be hostile.
  – The importance of recognizing the return/worsening of symptoms and of coming back for re-assessment should be stressed.
  – The importance of including the person in family and other social activities should be stressed.
  – Family members should avoid expressing constant or severe criticism or hostility towards the person with psychosis.
  – People with psychosis are often discriminated against but should enjoy the same rights as all people.
  – A person with psychosis may have difficulties recovering or functioning in high-stress working or living environments.
  – It is best for the person to have a job or to be otherwise meaningfully occupied.

– In general, it is better for the person to live with family or community members in a supportive environment outside hospital settings. Long-term hospitalization should be avoided.

2.2 Facilitate rehabilitation in the community

» Coordinate interventions with health staff and with colleagues working in social services, including organizations working on disabilities.

» Facilitate liaison with available health and social resources to meet the family’s physical, social and mental health needs.

» Actively encourage the person to resume social, educational and occupational activities as appropriate and advise family members about this. Facilitate inclusion in economic and social activities, including socially and culturally appropriate supported employment. People with psychosis are often discriminated against, so it is important to overcome internal and external prejudices and work toward the best quality of life possible. Work with local agencies to explore employment or educational opportunities, based on the person’s needs and skill level.

– If needed and available, explore housing/assisted living support. Consider carefully the person’s functional capacity and the need for support in advising and facilitating optimal housing arrangements, bearing in mind the human rights of the person.

2.3 Follow-up

» People with psychosis require regular follow-up.

» Initial follow-up should be as frequent as possible, even daily, until acute symptoms begin to respond to treatment. Once the symptoms have responded, monthly to quarterly follow-up is recommended based on clinical need and feasibility factors such as staff availability, distance from clinic, etc.

» Maintain realistic hope and optimism during treatment.

» At each follow-up, assess symptoms, side-effects of medications and adherence. Treatment non-adherence is common and involvement of carers is critical during such periods.

» Assess for and manage concurrent medical conditions.

» Assess for the need of psychosocial interventions at each follow-up.
Psychosis

Intervention Details

Pharmacological Interventions

3.1 Initiating antipsychotic medications

- For prompt control of acute psychotic symptoms, health-care providers should begin antipsychotic medication immediately after assessment. Consider acute intramuscular treatment only if oral treatment is not feasible. Do not prescribe depot/long-term injections for prompt control of acute psychotic symptoms.

- Prescribe one antipsychotic medication at a time.

- “Start low, go slow”: Start with a low dose within the therapeutic range (see the antipsychotic medication table for details) and increase slowly to the lowest effective dose, in order to reduce the risk of side-effects.

- Try the medication at an optimum dose for at least 4–6 weeks before considering it ineffective.

- Oral haloperidol or chlorpromazine should be routinely offered to a person with psychotic disorder.

### Table: Antipsychotic Medications

<table>
<thead>
<tr>
<th>Medication:</th>
<th>Haloperidol</th>
<th>Chlorpromazine</th>
<th>Fluphenazine depot/long-acting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting dose:</td>
<td>1.5 – 3 mg</td>
<td>75 mg</td>
<td>12.5 mg</td>
</tr>
<tr>
<td>Typical effective dose (mg):</td>
<td>3 – 20 mg/day</td>
<td>75 – 300 mg/day*</td>
<td>12.5 – 100 mg every 2 – 5 weeks</td>
</tr>
<tr>
<td>Route:</td>
<td>oral/intramuscular (for acute psychosis)</td>
<td>oral</td>
<td>deep intramuscular injection in gluteal region</td>
</tr>
<tr>
<td><strong>Significant side-effects:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sedation:</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Urinary hesitancy:</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Orthostatic hypotension:</td>
<td>+</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>Extrapyramidal side-effects:**</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Neuroleptic malignant syndrome:***</td>
<td>rare</td>
<td>rare</td>
<td>rare</td>
</tr>
<tr>
<td>Tardive dyskinesia:****</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>ECG changes:</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Contraindications:</td>
<td>impaired consciousness, bone marrow depression, pheochromocytoma, porphyria, basal ganglia disease</td>
<td>impaired consciousness, bone marrow depression, pheochromocytoma</td>
<td>children, impaired consciousness, parkinsonism, marked cerebral atherosclerosis</td>
</tr>
</tbody>
</table>

This table is for quick reference only and is not intended to be an exhaustive guide to the medications, their dosing and side-effects. Additional details are given in "Pharmacological Treatment of Mental Disorders in Primary Health Care" (WHO, 2009) ([http://www.who.int/mental_health/treatment_of_mental_disorders_in_primary_health_care/en/index.html](http://www.who.int/mental_health/treatment_of_mental_disorders_in_primary_health_care/en/index.html)).

* Up to 1 g maybe necessary in severe cases.
** Extrapyramidal symptoms include acute dystonic reactions, tics, tremor, and cogwheel and muscular rigidity.
*** Neuroleptic malignant syndrome is a rare but potentially life-threatening disorder characterized by muscular rigidity, elevated temperature and high blood pressure.
**** Tardive dyskinesia is a long-term side-effect of antipsychotic medications characterized by involuntary muscular movements, particularly of the face, hands and trunk.
Grand Challenges in Global Mental Health: Integration in Research, Policy, and Practice

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Introduction

More than a decade ago, the World Health Organization’s (WHO) World Health Report 2001 called for the integration of mental health into primary care, acknowledging the burden of mental, neurological, and substance use (MNS) disorders globally; the lack of specialized health care providers to meet treatment needs—especially in low- and middle-income countries (LMICs); and the fact that many people seek care for MNS disorders in primary care [1]. In 2012, the Global Burden of Disease (GBD) Study 2010 confirmed the still urgent need for attention to MNS disorders: over the past 20 years, the disability adjusted life years (DALYs) attributable to MNS disorders rose by 30%, and mental and behavioral disorders account for nearly one quarter of all years lived with a disability [2]. MNS disorders also contribute indirectly to mortality, through suicides and conditions like cirrhosis, which, in certain regions, both rank among leading causes of disease burden [2].

The GBD Study 2010 brought welcome news of reductions in the DALYs for communicable, maternal, neonatal, and nutritional disorders since 1990. This progress is due, in part, to coordinated, global cooperation to meet the Millennium Development Goals (MDGs) and, specifically, to achieve targets set for child survival, maternal health, and combatting HIV/AIDS and malaria by 2015. Crucial for the global public health community, investments in achieving the health-related MDGs catalyzed the development, testing, and implementation of effective health interventions for priority conditions and stimulated the development of packages of care that bundle effective interventions—whether for reduction of maternal or child mortality or for HIV care and treatment. Stakeholders recognize that “synergies in the health system must be pursued” [4], and that these packaged interventions can be delivered most effectively through integrated approaches to care [5].

The need for integrated care that addresses emerging priority conditions, like non-communicable diseases (NCDs), including MNS disorders, is acknowledged less frequently in the global context [6]. As a result of global population growth, aging, and epidemiologic and demographic transitions, NCDs account for more than 60% of deaths worldwide, with disproportionate rates of mortality among populations in LMICs [7]. Significantly, MNS disorders frequently occur throughout the course of many NCDs and infectious diseases, increasing morbidity and mortality [8–11]. Consequently, people suffering with co-morbid disorders, such as depression and HIV or post-traumatic stress disorder and coronary heart disease, risk poor outcomes for both disorders. Achieving desired outcomes for priority programs will be difficult without managing MNS disorders.

At a minimum, packages of care for MNS disorders should be paired with effective interventions in primary care or other priority health delivery platforms. In truth, adequate attention to the public’s health requires that this integration also occur in sectors beyond health (e.g., education, justice, welfare, and labor), through collaborative partnerships of government, non-governmental organizations (NGOs), and faith-based organizations, as well as in the implementation of global health and development policy.

The Grand Challenge of Integrating Care for MNS Disorders with Other Chronic Disease Care

Despite the increasing burden of MNS disorders around the world and their frequent co-morbidities, affected individuals often lack access to mental health care in high-, middle-, and low-income countries [12]. Inadequate investments in mental health care are partially responsible. Costs associated with mental illness…


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Abbreviations: DALY, disability adjusted life years; GBD, global burden of disease; GCGMH, Grand Challenges in Global Mental Health; LMIC, low- and middle-income country; MNS, mental, neurological, and substance use; mhGAP, Mental Health Gap Action Programme; MDG, Millennium Development Goal; NCD, non-communicable disease; NHM, National Institute of Mental Health; NGO, non-governmental organizations; WHO, World Health Organization.

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Key Research Questions for GMH

- the relevance of existing nosological systems and their impact on help-seeking, illness course and treatment response
- development of assessment approaches sensitive to local idioms of distress
- understanding and supporting local modes of coping, resilience and recovery
- evaluating the impact of mental health interventions in social/cultural context
- assessing the costs and benefits of globalized and indigenous healing systems
Dilemmas of the GMH Movement

• Recent debates on global mental health have raised questions about the goals, methods, and consequences of current approaches.

• These critiques emphasize the difficulties and potential dangers of applying Western categories, concepts, and interventions given the many different ways that culture shapes illness experience.

• The concern is that in the urgency to address disparities in global health, ways of framing problems and intervening that are not culturally consonant will be exported to local populations with negative effects.
Critiques of the GMH Logic

Critics of the GMH movement challenge each of the core assumptions:

1. estimates of the prevalence and toll of mental health problems in most parts of the world are based on uncertain/questionable extrapolation that lead to inflated or misleading figures;

2. economic inequality, structural violence, war and conflict on both local and global scales are far more important determinants of health than the types of problems recognized in international mental health mental health;

3. framing the disparities in terms of a treatment gap privileges mental health services and interventions as an appropriate response by mental health professionals is self-serving and ignores community-based and grassroots approaches;

4. evidence-based practices developed in Western countries may not be culturally appropriate, feasible, or effective in other contexts. Moreover, the demand to scale-up evidence-based practices may pre-determine the types of intervention available.
Culture and Context in GMH

Cultural considerations contribute to all four arguments:

1. the ways that problems are categorized and counted depends on culturally-rooted systems of psychiatric nosology

2. the social determinants of health are depend on culturally mediated distinctions between groups that vary across societies

3. the local response to suffering is embedded in cultural systems of meaning and healing that are part of the religious, spiritual and moral fabric of communities and societies

4. the production of evidence is shaped by cultural assumptions, and the fit (or adaptability) of interventions across cultures depends crucially on the generalizability of these concepts, values and practices.
Persistent Controversies

• varying levels of agreement about the universal applicability of existing diagnostic categories and treatments

• varying levels of agreement about the quality of available interventions and the evidence as to what works

• concern about the type of outcomes measured and their relevance to different social and cultural contexts and

• concern about the need to protect and promote, local, indigenous methods of helping, healing and recovery.
Social Determinants in Global Mental Health

- GMH programs have tended to downplay addressing SDH in favour of focus on mental health services
- this reflects the individualistic orientation of biomedicine
- it also reflects the priorities of health funders and policy makers and national and international levels
- the result privileges mental health services and gives less emphasis to primary prevention, grass-roots interventions, and community development
Toward a new architecture for global mental health

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Abstract
Current efforts in global mental health (GMH) aim to address the inequities in mental health between low-income and high-income countries, as well as vulnerable populations within wealthy nations (e.g., indigenous peoples, refugees, urban poor). The main strategies promoted by the World Health Organization (WHO) and other allies have been focused on developing, implementing, and evaluating evidence-based practices that can be scaled up through task-shifting and other methods to improve access to services or interventions and reduce the global treatment gap for mental disorders. Recent debates on global mental health have raised questions about the goals and consequences of current approaches. Some of these critiques emphasize the difficulties and potential dangers of applying Western categories, concepts, and interventions given the ways that culture shapes illness experience. The concern is that in the urgency to address disparities in global health, interventions that are not locally relevant and culturally consonant will be exported with negative effects including inappropriate diagnoses and interventions, increased stigma, and poor health outcomes. More fundamentally, exclusive attention to mental disorders identified by psychiatric nosologies may shift attention from social structural determinants of health that are among the root causes of global health disparities. This paper addresses these critiques and suggests how the GMH movement can respond through appropriate modes of community-based practice and ongoing research, while continuing to work for greater equity and social justice in access to effective, socially relevant, culturally safe and appropriate mental health care on a global scale.

Keywords
community mental health, culture, globalization, global mental health, political
Basic Issues

• Global mental health exists against the historical background and ongoing reconfigurations of colonialism, postcolonialism, neocolonialism, and the contexts of globalization

• Psychologization and psychiatrization play an important role in emerging forms of personhood in modernity

• Psychiatric institutions contribute to social control, regulation, and legitimation not only through carceral functions but increasingly through epistemic regimes of evidence and authority

• The process of making global mental health a movement aims to mobilize resources but raises a set of new political, organizational and conceptual questions
Individual Clinical Problems

At the level of *individuals and families* in clinical care, negative effects may occur…

- through diagnosis and assessment that uses nosological systems that are not appropriate for local cultural contexts, resulting in misdiagnosis
- by failing to recognize relevant personal and social problems that demand solutions other than mental health treatment
- by applying treatments of uncertain value
- by undermining local modes of understanding, explaining and effectively coping with affliction
- by stigmatizing individuals through associations with psychiatric illness
Health Systems & Community Problems

At the level of health systems, institutions, communities and populations, negative effects may occur...

• by displacing attention from social structural and political economic determinants of mental health toward their distal mental health effects on individuals;

• by adopting the economic agendas of multinational pharmaceutical corporations or other interests that may ultimately conflict with public health goals;

• by ignoring, invalidating or displacing indigenous systems of mental health promotion and healing that are part of the social fabric and resilience of local communities;

• by undermining community autonomy and self direction in favour of professional, technocratic, expert-driven approaches associated with mental health services.
Perinatal depression in Nigeria: perspectives of women, family caregivers and health care providers

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Abstract

Background: Perinatal maternal depression is common and undertreated in many sub-Saharan African countries, including Nigeria. While culture shapes the social determinants and expression of depressive symptoms, there is a dearth of research investigating these processes in African contexts.

Methods: To address this gap, we conducted in-depth interviews with 14 women with perinatal depression, 14 of their family caregivers and 11 health providers, using the McGill Illness Narrative Interview as part of a larger trial of a stepped-care intervention. Interpretation of themes was guided by cultural constructivist and critical anthropological perspectives that situate perinatal depression in its complexity as a disorder that is embedded in webs of social relations and embodied practices.

Results: Study respondents used idioms of distress that identified perinatal conditions that consist of somatic, affective, cognitive and behavior symptoms found in depressive disorders. Respondents viewed mental health problems in the perinatal period as tied to sociomoral concerns over gender roles and women's position within the household. Conflict between women's effort to be assertive to address interpersonal problems, while needing to be seen as non-aggressive contributed to their distress. Causal explanations for depression included husband's lack of care, family problems, “spiritual attack”, having a female child when a male child was desired, and not resting sufficiently after childbirth. Guilt about breaching social norms for women’s conduct contributed to self blame, and feelings of shame.

Conclusions: Clinical assessment and interventions as well as public health prevention strategies for perinatal depression in global mental health need to consider local social contexts and meanings of depression, which can be explored with narrative-based methods.

Keywords: Nigeria, Perinatal depression, Qualitative interviews, Illness explanatory models
thinking too much (see Table 2; Fig. 1). Both symptoms and causes of perinatal depression were described in relation to social suffering and interpersonal challenges in the local social worlds, linked to social roles, norms and statuses. Perinatal depression was described as linked to negative emotions, particularly regret and self-blame that women experienced when they breached social and cultural norms (e.g. refusing parents wishes in choice of marriage partners) only to later find that their choices had a poor outcome (e.g. ending up with an abusive partner):

Interviewer: What caused your health problem?
Patient: My husband was dating one woman and myself at the same time, impregnated two of us and got married to two of us without our awareness.

Interviewer: Are there any other causes that you think played a role?
Patient: My parents did not want me to be married to my husband… but I refused, so when I later saw what was going on, I felt disturbed and blamed myself.

As shown in the excerpt above, women's experience of illness was often presented as linked to a conflict between being self-assertive (e.g. choosing one's own husband) yet wanting to be seen as genial, cooperative, and non-oppositional (e.g. unquestioning trust in husband). This conflict may reflect women's awareness of the dangers of being seen as "aggressive" in a patriarchal social system coupled with the recognition that if they do not safeguard their own interests they risk having basic needs unmet.

Family problems and husband not caring also spoke to this conflict linked to women's low status in patriarchal household situations in which women's rights and subjection were constrained by gender roles and norms. Lack of support from a spouse was often described in households in which the patient, her spouse, mother-in-law...

*Naturalistic explanations: balance theories, local theories of stress, sleeplessness

**Fig. 1** Explanatory models of patients, caregivers and health providers
Culture and depression in global mental health: An ecosocial approach to the phenomenology of psychiatric disorders

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1. Introduction: The global burden of depression

Depression is a major focus of concern in global mental health, with epidemiological surveys indicating high prevalence rates worldwide (Ferrari et al., 2013a). Estimates of the global burden of depression in terms of disability, quality of life, and economic impact have been used to argue for scaling up the detection and treatment of depression as a public health and development priority in low and middle-income countries (Chisholm et al., 2016; Patel, 2017). These projections, however, are based on limited data and make many assumptions about the generalizability of findings across populations. While epidemiological research suggests there is substantial cross-cultural variation in the prevalence and symptomatology of depression (Ferrari et al., 2013b; Kessler and Bromet, 2013), there is evidence that a syndrome similar to major depressive disorder can be identified across diverse cultural contexts (Kleinman and Good, 1985; Kirmayer and Jarvis, 2006; Steel et al., 2014).

In a useful contribution, Haroz and colleagues (Haroz et al., 2017) reviewed the qualitative literature on cultural variations in depression to gauge the extent to which current diagnostic criteria fit the experience of people in diverse contexts. They found significant cultural variation and call for an expanded research program to explore the meaning and significance of these cultural differences for our understanding of mental health. This is crucial for current efforts to address global inequities in mental health and to make sense of claims of a global “epidemic” of depression (Baxter et al., 2014).

In this commentary, we examine the methods and findings of Haroz and colleagues’ study and discuss implications for future research on depression and the development of interventions in global mental health.

2. Thinking inside the box: qualitative studies of the symptoms of depression

In a useful contribution, Haroz and colleagues (Haroz et al., 2017) reviewed the qualitative literature on cultural variations in depression to gauge the extent to which current diagnostic criteria fit the experience of people in diverse contexts. They found significant cultural variation and call for an expanded research program to explore the meaning and significance of these cultural differences for our understanding of mental health. This is crucial for current efforts to address global inequities in mental health and to make sense of claims of a global “epidemic” of depression (Baxter et al., 2014).

In this commentary, we examine the methods and findings of Haroz and colleagues’ study and discuss implications for future research on depression and the development of interventions in global mental health.
Considering culture, context and community in mhGAP implementation and training: challenges and recommendations from the field

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Abstract
Background: Major efforts are underway to improve access to mental health care in low- and middle-income countries (LMIC) including systematic training of non-specialized health professionals and other care providers to identify and help individuals with mental disorders. In many LMIC, this effort is guided by the mental health Gap Action Programme (mhGAP) established by the World Health Organization, and commonly centres around one tool in this program: the mhGAP-Intervention Guide.

Objective: To identify cultural and contextual challenges in mhGAP training and implementation and potential strategies for mitigation.

Method: An informal consultative approach was used to analyze the authors’ combined field experience in the practice of mhGAP implementation and training. We employed iterative thematic analysis to consolidate and refine lessons, challenges and recommendations through multiple drafts. Findings were organized into categories according to specific challenges, lessons learned and recommendations for future practice. We aimed to identify cross-cutting and recurrent issues.

Results: Based on intensive fieldwork experience with a focus on capacity building, we identify six major sets of challenges: (i) cultural differences in explanations of and attitudes toward mental disorder; (ii) the structure of the local health-care system; (iii) the level of supervision and support available post-training; (iv) the level of previous education, knowledge and skills of trainees; (v) the process of recruitment of trainees; and (vi) the larger socio-political context. Approaches to addressing these problems include: (1) cultural and contextual adaptation of training activities, (2) meaningful stakeholder and community engagement, and (3) processes that provide support to trainees, such as ongoing supervision and Communities of Practice.

Conclusion: Contextual and cultural factors present major barriers to mhGAP implementation and sustainability of improved services. To enable trainees to effectively apply their local cultural knowledge, mhGAP training needs to: (1) address assumptions, biases and stigma associated with mental health symptoms and problems; (2) provide an explicit framework to guide the integration of cultural knowledge into assessment, treatment negotiation, and delivery; and (3) address the specific kinds of problems, modes of clinical presentations and social predicaments seen in the local population. Continued research is needed to assess the effectiveness these strategies.

Keywords: mhGAP, Global Mental Health, Primary care, Integration, Task shifting, Cultural adaptation, Implementation
variables. These codes were used to produce an alluvial diagram using the open source Web application RawGraphs (see Fig. 1).

Findings and discussion

We identified six sets of cultural/contextual issues that require consideration in mhGAP implementation: (i) cultural differences in explanations of and attitudes toward mental disorders; (ii) the structure of the local healthcare system; (iii) the level of supervision and support available post-training; (iv) the level of previous education, knowledge and skills of trainees; (v) the process of recruitment of trainees; and (vi) the larger socio-political context of the region.

Cultural differences in explanations of and attitudes toward mental disorders

Cultural knowledge, attitudes and practices exert strong effects on help-seeking, treatment referral, adherence, and response to interventions. Although trainees with local cultural knowledge are an essential resource in mental health service delivery, they present specific challenges to standardized mhGAP training: (1) trainees may share cultural beliefs, and assumptions with others in their local culture that lead to biases and stigma toward mental illness; (2) trainees may be unclear how to apply their cultural knowledge to the specific tasks of mhGAP; and (3) the local context may include particular types of clinical problems, presentations, and social predicaments not explicitly addressed in mhGAP.

Cultural attitudes toward mental disorders are important factors in service provision. Stigmatizing cultural beliefs, explanatory models and attitudes shared by both patients and mental health workers (e.g., the concern that mental disorders are contagious or involve supernatural causes that cannot be addressed by biomedicine) will shape service delivery. Lack of attention to cultural context on the part of providers and decision-makers can lead to mistrust of mental health information and services and reduce motivation to engage with mental healthcare or adhere to treatment [43, 44]. In our experience, it is not uncommon to meet health practitioners who are convinced that mental disorder in a specific patient is due to curses, spirit possession, or to patients having behaved in ways that angered the ancestors. Some health providers who accepted the premise that psychotic symptoms had supernatural causes, believed this could confer immunity to physical illnesses. Such views among health care providers may affect interactions with patients and influence treatment choices.

Of course, the impact of cultural beliefs is not confined to mental conditions. Given that physical illnesses often provide signs that point to the presence of known biological agents, biomedical services may be more likely to be sought for physical conditions, but cultural meanings and implications remain a critical ingredient in the negotiation of care [45]. In the absence of visible signs of disease, as is usually the case for mental disorder, there may be greater uncertainty about the nature of the affliction and its causes. A recent study in Uganda evaluating

Fig. 1 Correspondence of type of challenges in mhGAP training and implementation and potential solutions
Toward an Ecosocial Psychiatry

Abstract
Social psychiatry is grounded in the recognition that we are fundamentally cultural beings. To advance the field, we need integrative theory and practical tools to better understand, assess, and intervene in the social-ecological cultural systems that constitute our selves and personhood. Cognitive science supports the view that mental processes are intrinsically social, embodied, and enacted through metaphor, narrative, and discursive practices. The circuits of the mind, therefore, extend beyond the brain to include our interactions with others through bodily and verbal communication. This ecosocial view of mind, brain, and culture calls for a shift in perspective from a psychiatry centered on brain circuitry and disorders toward one that recognizes social predicaments as the central focus of clinical concern and social systems or networks as a crucial site for explanation and intervention. The ecosocial perspective insists that we consider the powerful effects of structural violence and social inequality as key determinants of health. Social systems also have their own dynamics which can amplify inequities or provide sources of resilience. These social processes are framed, mediated, and maintained by cultural narratives, models, and metaphors. Hence, cultural analysis and critique must be foundational to social psychiatry. This opens the door to a creative engagement with human diversity in all its forms.

Keywords: Culture, ecosocial, psychiatry

INTRODUCTION
Social psychiatry is grounded in the recognition that we are fundamentally cultural beings. Our brains are designed to acquire culture to navigate a social world, find support from others, and cooperate to construct our own ecocultural niche. For the last 50,000 years, we have been co-evolving with those niches, developing a vast array of cultures, languages, and forms of communal life to adapt to the demands of varied environments. This sociality is reflected in the architecture of our brains, which are organized to process social information, but especially in their plasticity, which allow us to acquire culture over decades of development. The brain is remodeled and rewired in response to the ways that we use it, with the result that we carry cultural knowledge, values, and skills within us in our personal storehouse of memory and capacity to respond to situations. However, most of the culture remain without, in the social environment, structured as affordances to which we respond based on our social position, norms, expectations, and aspirations.

Cognitive science increasingly supports the view, first tendered by phenomenology, that mental processes are intrinsically social. The circuits of the mind extend out into the world, through our tools, discourse, practices, and institutions that enable cooperation. The world presents itself to us in terms of its affordances for action and perception, and these affordances are preeminently social and cultural. The collective knowledge, tools, and insights of previous generations are available to us through archives, and we scaffold more complex cognition on this cultural history, which is sedimented in language and present to us in our institutions and practices. In effect, we are able to extend the reach of our thoughts by thinking through other minds. All of this makes social psychiatry not simply an “add-on” or supplement to biological psychiatry, but a necessity if we wish to understand the basic mechanisms of mental disorders and their effective treatment.

This social view of the brain has received new precision through the current work...
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